**INTERIM PROJECT**

# An examination of the Medicaid upper payment limit (UPL) program, hospital disproportionate share (DSH) program, intergovernmental transfers (IGT) and Low-Income pool.


**Health Care General Committee**
**Florida House of Representatives**
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## Executive Summary

**Purpose**

The purpose of this interim project report is to provide a simplified and basic understanding of how the Upper Payment Limit (UPL), the Disproportionate Share Hospital (DSH), and Intergovernmental Transfers (IGT) operate, the role these supplemental funding mechanisms play in increasing access to Medicaid and subsidizing uncompensated or charity care, the issues surrounding the use of these funding mechanisms, the evolving federal perspective and policy in this area and the implication of the Low-Income Pool for Florida's approved Medicaid Reform waiver implementation.

**Federal Matching Funds**

The Federal Government pays the largest share of medical assistance expenditures for the state's Medicaid program. This federal share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level receive a smaller share of federal matching funds to cover the cost of the Medicaid program. Florida's FMAP for Medicaid services was set at 58.90% in FFY 2005. This means that approximately every $40 the state spends on Medicaid services, Florida receives $60 from the Federal Government. There are other FMAP rates for administrative and technology functions but the biggest impact on the states budget is the FMAP for Medicaid services.

**Funding Mechanisms**

While the FMAP and the state's general revenue match are the backbone of the Medicaid system, other supplemental funding mechanisms are allowed and used that are critical to the state's effort to ensure access to health services by Medicaid recipients and the uninsured. Combined these funding mechanisms are principal sources of supplemental funding to ensure access to inpatient and specialty care by more than 2 million Medicaid recipients and access to Florida's safety-net hospitals by the approximately 3 million uninsured when they seek care. These funding mechanisms include:

**DSH**

- **Medicaid Disproportionate Share Hospital (DSH)**
  DSH is a supplemental funding mechanism to compensate hospitals for the added costs of serving a disproportionate share of low-income individuals who either are part of the Medicaid program or have no insurance at all. The Federal Government requires that all states have a disproportionate share program. Federal funds allocated to a state are used to assist hospitals that provide a disproportionate share of Medicaid and charity care services. Under DSH, states are allowed to make payments in addition to Medicaid payments, within limits established by federal regulations, to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the DSH payment adjustment. To qualify for DSH, a hospital must meet certain statutory criteria regarding Medicaid and charity care.

**UPL**

- **Hospital UPL**

  Hospital UPL is a supplemental payment mechanism based upon an interpretation of federal Medicaid regulations (42 CFR 447) that allow states to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare payment for hospital services.

  The upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the hospitals under Medicare payment principles in the aggregate. Medicare has a higher reimbursement rate for services than Medicaid. This supplemental payment mechanism allow states within parameters established by the Federal Government to make higher special Medicaid payments to compensate certain hospitals by making up the difference between what Medicaid pays and what Medicare pays for certain hospital services. In Florida, there are three UPL programs: Nursing Homes, Hospital, and Physician. This report focuses on Hospital and Physician UPL.

**Physician UPL**

Because the Medicaid fee schedule reimbursements are comparatively low, Medicaid patients throughout Florida typically have a difficult time securing subspecialty care. The Physician UPL/Enhanced Medicaid Payment Program was created to supplement Medicaid payments for services provided to Medicaid recipients treated at Florida's medical schools. Like the hospital UPL program, the Physician UPL program is based upon an interpretation of federal Medicaid regulations (42 CFR 447) that allow states to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare fees or usual and customary charges for certain services. Florida's Physician UPL program allows supplemental payments for Medicaid services provided by doctors providing Medicaid services who are employed by a public or private university medical school or teaching hospital. The Physician UPL program uses the same principle to draw down additional federal match. These supplemental payments are intended to increase access to care for Medicaid patients. But unlike the Hospital UPL program that relies on county generated IGT, the Physician UPL program relies on general revenue as its IGT source. The problem with general revenue as IGT for the medical schools has been a shrinking general revenue source.

**IGT**

IGT are fund exchanges between government and the state's Medicaid program. A common feature in state financing of the Medicaid program, IGT leverage the state's ability to draw down additional federal funds. IGT are a way for the state to fund the match required for Medicaid expenditures. The DSH and Hospital UPL programs are supported by IGT payments that provide the match to draw down the federal funds for these programs. The Physician UPL program IGT is supported by general revenue through the education budget to support physicians employed or under contract with a medical school that is part of the state university system or medical schools that are part of private universities.

**DSH Council**

The DSH, UPL and IGT process that culminates in supplemental payments to qualified hospitals in Florida as provided in the annual Appropriations Act centers around the work of the DSH Council. The council is charged with studying, developing a methodology and making recommendations regarding the formula for the Disproportionate Share Hospital Program (DSH) and alternative Medicaid financing options. The council is required to submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year. These recommendations are considered by the Legislature and included in the Appropriations Act.

**Fiscal Impact**

For FY 05/06, counties will provide approximately $493 million local government transfers through IGT. These funds will be utilized primarily to pay for the disproportionate share hospital program, as well as to provide special Medicaid payments to hospitals. DSH payments in FY 05/06 are projected to total approximately $277 million and UPL payments will total approximately $1 billion (includes both Federal share and IGT).

**Criticism and Proposals to Change**

Although these funding mechanisms play a critical role in the financing of Medicaid services and charity care in all states, they are not without controversy and are sometimes viewed at the Federal level as fundamentally unfair. There have been numerous concerns and criticism directed at the way some states operate the Disproportionate Share Hospital (DSH), the Upper Payment Limit (UPL) and Intergovernmental Transfer (IGT) payments to maximize the federal matching funds. These criticisms come from the Federal Administration, certain members of congress, CMS, and other Federal Government agencies.

In general, critics view the supplemental financing mechanism as designed solely to maximize Federal reimbursements to States, in contradiction to the federal and state cost-sharing principles as embodied in the FMAP and serve to disguise the source and final use of both Federal and State funds. One study estimated that the effective Medicaid federal match rate rises three percent as a result of states use of IGT to leverage UPL. Applying this assumption to the Florida UPL program, the true Federal match is closer to 63% rather than the actual 58.90 % in FFY 2005. Another point of contention is that even with the infusion of federal Medicaid dollars, some states are not using the new funds to improve or expand allowable health care services for Medicaid beneficiaries or low-income and uninsured people. Like other Medicaid matching funds, federal funds generated through these mechanisms become unaccountable once they reach the states and can be used for a range of purposes, including non-health related budget items. In the past, some states have been identified for "recycling" Federal dollars back to state general revenue. Florida was not identified as one of the states that "recycles".

In addition, the explosive growth in the supplemental payment mechanism has also generated related concerns. Federal and state UPL expenditures through all UPL arrangements grew from an estimated $10.3 billion in 28 states in FY 2000 to $11.2 billion in 43 states in FY 2004. This growth would have been higher, but it occurred during a period that Congress and CMS acted to limit excessive UPL arrangement and claims. When a state uses IGT to match Federal dollars for DSH and the UPL program,

the state's share of the cost (general revenue) declines but increases the Federal share of the cost. As a result, there are recommendations and proposals to limit, alter or dismantle the DSH, UPL, and IGT programs.

The continuing challenge to the integrity of DSH, UPL and IGT is finding the proper balance between a state's flexibility to administer its Medicaid program and the shared federal-state fiduciary responsibility to manage program finances efficiently in a way that ensures the program's fiscal integrity. Some of the proposals to change these funding mechanisms include:

- New regulations to lower or cap the Medicaid UPL for public hospitals. This regulation would limit how much states could reimburse such hospitals, which would have the effect of reducing federal Medicaid matching payments to a number of states.
- Limits on the use of IGT and better accountability measures to ensure that IGT are not used as a vehicle to support inappropriate Medicaid financing.
- Limits on federal matching payments to states for reimbursements to DSH hospitals.
- The use of other strategies to serve the uninsured such as a "Low-Income pool"

In the aftermath of Hurricanes Katrina and Rita there are discussions in Congress to postpone any major changes to Medicaid that might cause a disruption or affect access to current services. However, the establishment of a Low-Income pool is a condition of the approved Florida Medicaid reform waiver and likely to receive the most scrutiny from the Legislature and providers.

**Low-Income Pool**

Low-Income Pool

In the Medicaid Reform waiver application the Agency specifically requested waivers of federal statutory provisions under the Social Security Act to provide for the establishment of a Low-Income Pool, in lieu of the UPL. The Low-Income Pool will be maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured. Funds from the Low-Income Pool will be distributed to safety-net providers that meet certain state and federal requirements regarding charity care or uncompensated care.

On October 19, 2005 the Agency received approval from CMS on Medicaid Reform Section 1115 Demonstration waiver. Accompanying the approval were "Special Terms and Conditions (STC) for the Florida Medicaid Reform section 1115 demonstration. The STC set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the Demonstration for a 5-year period, from July 1, 2006, through June 30, 2011. The Agency will need to comply with these terms and conditions (see Section 9 of the report). Among the most critical terms and conditions is the development of a reimbursement and funding

methodology for the Low-Income Pool and the CMS approval of the source of non-Federal share used to access the Low-Income Pool.

Like UPL, the Low-Income Pool would function to support health care safety-net providers by subsidizing uncompensated care and increase access to care. A system or a formula would need to be established to distribute funds in the Low-Income Pool that validly addresses the burden of uncompensated care and that reduces the incentives to under serve the uninsured because of lack of compensation. The responsibility for developing a methodology to distribute funds from the Low-Income Pool will likely fall on the Agency and DSH council. The Agency anticipates that the DSH Council will play the same role it now plays in the UPL program and submit its findings and recommendations to the Governor and the Legislature regarding the use of the Low-Income Pool.

**Issues**

Some issues could emerge in the implementation of a Low- Income pool. Among these are:

- The development of a reimbursement and funding methodology for the Low-Income Pool
- The amount allocated to the Low-Income Pool in comparison to historical UPL balances and growth rate
- How IGT would be used to leverage the federal funds in the Low-Income Pool
- Would current IGT be approved by CMS as match?
- Would local government (counties), through IGT, participate in a Low-Income Pool at the historical level of UPL and what would be the incentives for this participation
- The types of entities that qualify for the Low-Income Pool versus the types of entities that are allowed to participate in the Low-Income Pool?
- Will the physician UPL program be part of the Low-Income Pool?
- What challenges will there be in the transition from UPL to Low-Income Pool?
- What will be the effect of the Low-Income Pool on access to care by the uninsured?

The issues surrounding the use of the Low-Income Pool will be examined in the evaluation of the waiver and, in fact, is one of the five evaluation objectives delineated in the waiver. The evaluation will also focus on describing the characteristics of individuals who receive services through the Low-Income Pool. As stated in the waiver application, the Agency expects that the availability of funds through the Low-Income Pool will increase access for select services for the uninsured in the service areas of the participating facilities.

The approved waiver projects on a statewide basis spending $1 billion per year or approximately $5 billion over the waiver's 5 year period on the Low-Income Pool for the uninsured. The current UPL appropriation for FY 05/06 is approximately $1 billion. The UPL allocation is made of two components, an enhanced Medicaid rate (also referred as "rebasing") for services to hospital and an allocation to address the uncompensated care by the uninsured. Applying these two components to the total UPL allocations in FY

05/06 approximately $300 million was allocated to hospital for Medicaid rate rebasing (enhanced Medicaid payment rate) and $668 million to distribution for uncompensated care of the uninsured. The amount allocated to the Medicaid rebasing (enhanced rate) will remain at $300 million. This amount will come from other parts of the Medicaid budget. Because of the removal of rebasing from the $1 billion Low-Income Pool allocation, the state has a cushion of approximately $300 million in the Low-Income Pool for growth to provide payments for uncompensated care in the future.

The Agency is confident the Low-Income Pool will function much like the UPL program. The traditional UPL program will not be operating in the state in FY 06/07 since the Legislature approved the implementation of the waiver.

**Managed Care**

Managed care and supplemental funding mechanism

Another concern regarding the future of UPL, its replacement, the Low-Income Pool, and IGT is how they will be affected by an increasingly larger managed care environment. The UPL is based on calculations using fee-for-service (FFS) days paid directly by the Medicaid program to a hospital. Managed care funding is based on a capitation rate per recipient paid to the managed care entity. The managed care entity pays the hospital directly for services used by the plan's enrollee. Therefore, as managed care increases there are fewer number FFS days billed by hospitals, and consequently the lower the UPL aggregate amount available in the calculation. If all hospital care was provided through managed care, theoretically, there would be no UPL calculation because there would be no FFS days.

The IGT issue in a managed care environment centers on how specific hospitals would benefit from an IGT. If there are no FFS days billed by a hospital, the enhanced Medicaid rates could be paid to the managed care plans (e.g. unrelated entities to the funding governments). Under the current UPL program, supported by IGT, local governments can influence or direct that a portion of the funds benefit a specific hospital that participates in the UPL program. If the IGT under managed care funded only higher capitation payments to managed care organizations, and the managed care organizations had no obligation to contract with specific hospitals or pay specific rates to a hospital, the counties would have no guarantees that their IGT would actually benefit their local providers. This could create a disincentive for counties to contribute or make IGT payments to the Medicaid program.

It is uncertain at this point how the Low-Income Pool methodology would accommodate a managed care environment. One possible strategy would be to count managed care hospital inpatient and outpatient days in the Low-Income Pool methodology. Another strategy would use Medicaid encounter data, required by supporting legislation and delineated in the Medicaid Reform waiver application, from the managed care organizations to determine the number of inpatient hospital days in a hospital and use this methodology in calculating hospital days. This would base utilization on a similar methodology used in calculating fee-for-service (FFS) days paid directly by the Medicaid program to a hospital. The viability of these methodologies will depend on the terms and

conditions placed on the use of the Low-Income Pool by CMS if and when the waiver is approved.

**Provisions to Protect Supplemental Funding Mechanisms**
This legislative directive in the Medicaid Reform legislation requires that waiver authority to implement Medicaid reform be contingent upon:

- Federal approval to preserve the UPL for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites
- Provisions to preserve the state's ability to use IGT.
- Provisions to protect the DSH program.

**How did the waiver approved by CMS impact these provisions?**

- UPL is replaced by the Low-Income Pool. The Low-Income Pool should behave like UPL and that is the Agency's expectation. However, it will be contingent on the methodology for the distribution of the funds. Although it appears sufficient with a cushion of $300 million to fund UPL based on historical spending levels, capped at $1 billion a year for five years, there is no additional growth factor in the Low-Income Pool.
- In the terms and conditions of the approved waiver it appears that the Low-Income Pool can be used to provide supplemental payment for providers in addition to hospitals.

  > "These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS."

  However, the Agency plans to use the Low-Income Pool to supplement only certain hospitals. Thus, the physician UPL program and other providers are unlikely to receive any benefit from the Low-Income Pool.
- The Low-Income Pool could address the directive to preserve a portion of these funds to serve as a risk pool for demonstration sites. Again it is contingent on the methodology that is developed.
- The IGT program appears not to be affected by the terms and conditions of the approved waiver. However, CMS prior to the waiver implementation is requiring the Agency to submit for CMS approval the source of non-Federal share used or IGT to access the Low-Income Pool funds. The Agency will not have access to Low-Income Pool funds until the source of non-Federal share has been approved by CMS. There is a potential that CMS could disallow some of the IGT that likely support the Low-Income Pool.
- The DSH program is not affected by the approved Medicaid Reform waiver and will remain the same.

**Summary**

Safety-net hospitals that serve a large number of Medicaid and uninsured patients require a robust DSH and UPL program because Medicaid reimbursement rates are relatively low and because these hospitals typically receive little or no reimbursement for the costs that they incur on behalf of uninsured patients. The state has an interest in ensuring that these mechanisms are maintained or that as Medicaid evolves and other methods of ensuring the financial viability of safety-net hospitals are in place that these financial mechanisms ensure the continuation of adequate support to safety-net hospitals in providing access to Medicaid recipients and to the uninsured.

The state also has an interest to ensure that current incentives are maintained so that counties continue to support the program with IGT. Without IGT to support the Low-Income Pool, the state would have to increase the general revenue appropriations to draw down the federal dollars. The Legislature can expect various provider types, e.g., physicians under the current physician UPL program, to make a valid case for their inclusion to receive a distribution from these funds. Support for the implementation of the waiver by these various provider types is likely to be contingent on whether they receive Low-Income Pool funds.

A critical task for the Legislature will be endorsing the methodology developed by the Agency and DSH Council for the distribution of funds in the Low-Income Pool that has the attributes and effects of the traditional UPL program and that provides incentives for counties to continue IGT contributions.

# Report

## Section 1 - Introduction

One of the most technically complex supplemental funding mechanisms in the Medicaid program is the state's use of the upper payment limit (UPL) program, hospital disproportionate share (DSH) program, and intergovernmental transfers (IGT). IGT involve the transfer of funds from local governments to the state or fund transfers between different state agencies. These fund transfers are used as the state share for Medicaid DSH and UPL payments to obtain federal matching dollars.

The federal matching dollars secured through these funding mechanisms are so important to the state that the 2005 Legislature granted authority[1] to the Agency for Health Care Administration (Agency) to pursue a waiver application to reform Medicaid contingent upon:

- Federal approval to preserve the upper-payment-limit funding mechanism for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites
- Provisions to preserve the state's ability to use intergovernmental transfers.
- Provisions to protect the disproportionate share program.

The purpose of this interim project report is to provide a simplified and basic understanding of how the Upper Payment Limit (UPL), the Disproportionate Share Hospital (DSH), and Intergovernmental Transfers (IGT) operate, the role these supplemental funding mechanisms play in increasing access to Medicaid and subsidizing uncompensated or charity care, the issues surrounding the use of these funding mechanisms, the evolving federal perspective and policy in this area and the implication of the Low-Income Pool for Florida's approved Medicaid Reform waiver implementation.

## Section 2 - The Uninsured

To understand the role of UPL, DSH and IGT it is important to understand the context of uncompensated or charity care. Most Floridians (82%) are insured by some form of either private or public health coverage. However, an estimated 18% of Florida's population is uninsured at anytime during a year. The following table delineates population by health insurance status in FY 2002 - 2003.

**Table – The Health Insurance Status of Floridians 2002-2003**

| Source of Insurance | FL Population | % | US Population | % |
|---|---|---|---|---|
| Employer | 7,956,640 | 48 | 156,270,570 | 54 |
| Individual | 990,350 | 6 | 13,593,990 | 5 |

[1] CS/CS/SB 838, Chapter No. 2005-133; codified as s. 409.91211, (1), F.S.

| | | | | |
|---|---|---|---|---|
| Medicaid | 2,007,000 | 12 | 38,352,430 | 13 |
| Medicare | 2,726,250 | 16 | 34,190,710 | 12 |
| Uninsured | 2,957,290 | 18 | 44,960,710 | 16 |
| Total | 16,637,520 | 100 | 287,368,410 | 100 |

(Source: Kaiser Foundation - Population Distribution by Insurance Status, state data 2002-03, U.S. 2003)

A recent survey study of the uninsured[2], funded by the Agency, described Floridians who lack health insurance coverage.

- Children age 18 or younger are 18.5% of the uninsured.
- Working-aged adults are 81.5% of the uninsured.
- Individuals within the age of 18 to 24 years are 15.8% of the uninsured.
- Individuals within the age of 25 to 34 years are 23.2% of the uninsured.
- Individuals within the age of 35 to 54 years are 34.1% of the uninsured.
- Individuals within the age of 55 to 64 years are 8.3% of the uninsured.

The survey also found that among uninsured working-aged adults, about a third do not have a job, either because they are actively seeking employment (20.9%) or because they are out of the work place (16.1%) due to schooling, disability, or family obligations. Another 13.9% are exclusively self-employed. About 37.3% of uninsured adults work full-time for an employer, while 11.9% are employed part-time.

**Section 3 -Charity Care**

Many of Florida's uninsured will get sick or need emergency care during a year. Many of these individuals seek care in a Florida hospital. The uninsured typically gain access to health care services through what are known as "safety-net" hospitals or facilities that typically include public hospitals, private non-profit hospitals, and community health centers, all of whom help shoulder the burden of uncompensated care. While a broad range of providers serve uninsured patients, the largest share of uncompensated care, in terms of dollars, is provided by hospitals.[3]

The U.S. Constitution does not guarantee a right to health care. However, there are federal laws and regulatory standards that provide access to health care. This framework is far more prevalent in health care facilities, especially hospitals. Most of the federal requirements concerning the obligation to provide health care services have relied upon the federal financing authority and therefore are features of programs that provide federal assistance to states such as the Hill-Burton Act and the Medicare and Medicaid programs. For example, as a condition of receiving grants and loans for construction and modernization of hospitals through the Hill-Burton Act, hospitals must provide a reasonable volume of services to persons unable to pay[4] In addition, federal antidiscrimination statutes, such as the Civil Rights Act of 1964, the Rehabilitation Act of

[2] A Profile of Uninsured Floridians, Findings from the 2004 Florida Health Insurance Study
R. Paul Duncan et al, February 2005, The Department of Health Services Research, Management and Policy, University of Florida.
[3] Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments;
Robert E. Mechanic, National Health Policy Forum, September 2004.
[4] See 42 US Code. § 291c(e)(2).

Title VI and most recently the American with Disabilities Act have also created obligations to provide care beyond providers that receive federal funds.

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act, commonly referred to as EMTALA, to ensure public access to emergency services regardless of ability to pay. EMTALA[5] imposes specific obligations on Medicare-participating hospitals (most if not all hospitals) that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer to another facility must be implemented by the hospital.

A recent report by the United States Government Accounting Office (GAO)[6] found that the cost burden of providing uncompensated care varied among three hospital groups. These groups included non-profit hospitals, for-profit hospitals and government[7] hospitals. GAO reviewed 169 Florida hospitals: 43% were non-profit; 46% were for-profit and 11% were government. GAO found that the amount of uncompensated care costs was $1.5 billion and that government hospitals, as a group, devoted substantially larger shares of their patient operating expenses to uncompensated care than did non-profit and for-profit hospitals. The non-profit hospitals' uncompensated care costs, as a percentage of patient operating expenses, were higher on average than those of the for-profit hospitals.

**Total Uncompensated Care Costs Incurred by Hospitals Reviewed for Florida, 2003**

| Total uncompensated care costs (in millions) | Non-profit (percent of total) | For-profit (percent of total) | State and local government (percent of total) |
|---|---|---|---|
| Florida $1,561 | 46% | 20% | 34% |

(Source: United States Government Accounting Office)

**Section 4 - Medicaid Basics**

Medicaid is a health insurance entitlement program under Title XIX of the Social Security Act. It is administered and funded through a joint federal and state effort. Medicaid assists certain people who can't afford medical care by paying their medical bills. The program targets individuals with low-income, but not all of the poor are

[5] See 42 US Code, SUBCHAPTER XVIII, Part D, § 1395dd

[6] NON-PROFIT, FOR-PROFIT, AND GOVERNMENT HOSPITALS Uncompensated Care and Other Community Benefits, United States Government Accounting , GAO-05-743T, May 2005

[7] The state and local government-owned hospitals in this statement refer to state-owned hospitals, such as those at state universities, and locally owned hospitals, such as county and city hospitals. Federal hospitals, such as those operated by the Department of Veterans Affairs, are not included in this definition.

eligible, and not all those covered are poor. Medicaid is a means-tested and categorical program. To qualify, applicants' income and resources must be within certain limits and must meet certain categorical definitions. The specific income and resource limitations that apply to each categorical eligibility group are set through a combination of Federal parameters and a state's definitions within the Federal parameters.

Title XIX of the Social Security Act allows considerable flexibility within the a states' Medicaid plan[8]; however, a state's Medicaid program must offer certain mandatory medical benefits to most categorically needy populations if federal matching funds are to be received. Florida's Medicaid program provides all of the mandatory medical benefits under its state plan but it also receive federal matching funds to provide optional services.

Medicaid services are delivered by health care providers that enroll and are deemed providers by the Agency for Health Care Administration. There are approximately 80,000 providers in the Florida Medicaid program. Providers includes hospitals, other health care facilities, managed care organizations, physicians, therapists, nurses, and other types of health care providers or health care support providers. Providers that choose to accept Medicaid must accept Medicaid payment as payment in full. Medicaid payments are made directly to the provider, not to the recipient.

**Section 5 -Payment for Medicaid Services**

Medicaid operates similar to a health insurance program. Medicaid functions as a health provider payment program. States are allowed to reimburse health care providers directly on a fee-for-service basis, or states may reimburse for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within federally imposed upper limits and specific restrictions, each state has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. Medicaid payments to providers are typically lower than Medicare (the government sponsored health insurance program primarily for individuals 65 years of age or older) payments and typically lower than payments made to providers by the private health insurance market. In some cases, low Medicaid reimbursement rate have created problems in accessing specialty care.

The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher

[8] The state Medicaid plan is the document that defines how each state will operate its Medicaid program. Each state submits their own plan to the Centers for Medicare and Medicaid Services (CMS) for approval. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement. Florida's State Plan may be viewed at http://www.cms.hhs.gov/medicaid/stateplans/toc.asp?state=fl

per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 % or higher than 83 %. In federal fiscal year (FFY) 2004, the FMAPs varied from 50 % in twelve states to 77.08 % in Mississippi. The Medicaid average FMAP is 60.2 %. Florida's FMAP was set at 58.90 % in FFY 2005.

Florida Medicaid contracts with a fiscal agent to conduct many operations of the program. The fiscal agent processes the fee-for-service and MediPass claims, enrolls non-institutional providers as Medicaid providers, and distributes Medicaid forms and publications to providers and beneficiaries. To pay bills, the fiscal agent, ACS, processes about 436,000 claims every day.

Florida Medicaid also contracts with managed care organizations (Health Maintenance Organizations, physician services networks, minority physician networks and other entities) on an actuarially certified monthly capitated rate per recipient through a contract. The managed care organizations are paid on a monthly capitated amount per member or enrollee by the Agency.

**Section 6 - Supplemental Funding Mechanisms**

While the FMAP and the state's general revenue match are the backbone of the Medicaid system, other supplemental payment and funding mechanisms are used that are critical to the state's effort to ensure access to Medicaid health services by Medicaid recipients and the uninsured. These mechanisms include the Medicaid Disproportionate Share Hospital (DSH) program, the Upper Payment Limit (UPL) program and are supported by Intergovernmental Transfer (IGT) payments that provide the match to draw down the federal funds targeted for DSH and UPL. Combined these mechanism are principal sources of supplemental funding for Florida's safety-net hospitals to ensure access for inpatient and specialty care to Medicaid recipients and the uninsured.

**Disproportionate Share Hospital (DSH)**

As noted earlier, Medicaid payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. However, Federal law allows states to make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. To qualify for DSH, a hospital must meet certain criteria delineated in statute.

The Federal Government requires that all states have a disproportionate share program to distribute state and federal funds to hospitals that provide a disproportionate share of Medicaid and charity care services. DSH was created by Congress to compensate hospitals for the added costs of serving a disproportionate share of low-income individuals who either are part of the Medicaid program or have no insurance at all.

The Federal Government allocates specific DSH fund amounts to a state but allows states the flexibility in determining the DSH payment methodology used in the state Medicaid program to compensate hospitals that provide a certain threshold of charity care. A state makes a DSH payment directly to a hospital to help finance the additional cost of serving the special needs of a community. Once the state has made such a DSH payment, the Federal Government reimburses the state for part of the payment, based on the state's Medicaid matching rate or FMAP (see Payment for Medicaid Services)

The rationale behind the special payments is that hospitals rendering high volumes of care to Medicaid recipients typically lose money because of historically low Medicaid reimbursement rates. They also lose money because these hospitals are often the same facilities that provide high volumes of care to indigent patients, causing them to have high levels of uncompensated care. DSH funds account for a significant proportion of Medicaid funding in Florida's "safety-net" facilities.

**Upper Payment Limit (UPL) Payments**

As a general rule, the upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities (hospitals) under Medicare payment principles in the aggregate for certain qualifying services. This supplemental payment mechanism is a complex funding arrangement between the state and the Federal Government where states are allowed to make special or enhanced Medicaid payments to compensate certain hospitals and providers to make up the difference between Medicaid and Medicare reimbursement fee rates. In Florida, there are three UPL programs: Nursing Homes, Hospital, and Physician. This report focuses on Hospital and Physician UPL.

**Hospital UPL**

Hospital UPL is a supplemental payment mechanism based upon an interpretation of federal Medicaid regulations (42 CFR 447) that allow states to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare fees or usual and customary charges for certain services.

Assume that a patient receives a service from a safety-net hospital. The charges for this service typically vary depending on the payer source. These billing differences occur because of differing payment arrangements negotiated with private insurers and predetermined fee schedules established by Medicare and Medicaid. Thus, if Medicare would reimburse $1,400 for a service and Medicaid would pay $900 for the same service, the UPL rules allow the safety-net hospital to bill Medicaid for an additional $500 to bring the total charge up to the Medicare standard. The federal/state share for the payment to the hospital would be $824 federal and $576 state.

Florida Medicaid uses Florida Hospital Uniform Reporting System (FHURS) reports to determine Medicare and Medicaid payment levels for allowable cost in the aggregate. Once the amount Medicare would have paid is determined, Medicaid payments per the

FHURS are deducted from the amount Medicare would have paid, and the difference is the UPL balance available. This available balance is separated into balances for public hospitals and private hospitals per federal regulations. The balances are the determination of how much can be distributed through the UPL.

The UPL allocation is made of two components, an enhanced Medicaid rate (also referred to as "rebasing") for services to hospital and an allocation to address the uncompensated care by the uninsured. Applying these two components to the total UPL allocations in FY 05/06 approximately $300 million was allocated to hospital for Medicaid rate rebasing and $668 million to distribution to hospitals for uncompensated care of the uninsured.

**Physician UPL**

Like the hospital UPL program, the Physician UPL program is based upon an interpretation of federal Medicaid regulations (42 CFR 447) that allow states to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare fees or usual and customary charges for certain services. Florida's Physician UPL program allows supplemental payments for Medicaid services provided by doctors providing Medicaid services who are employed by a public or private university medical school or teaching hospital. The Physician UPL program uses the same principle to draw down additional federal match. These supplemental payments are intended to increase access to care for Medicaid patients. But unlike the Hospital UPL program that relies on county generated IGT, the Physician UPL program relies on general revenue as its IGT source.

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The problem with general revenue as IGT for the medical schools has been a shrinking general revenue source. A report[9] by OPPAGA in 2003 highlighted this issue.

> "At any given time, UF (Gainesville and Jacksonville) and USF may not have cash readily available to submit to AHCA to serve as the state match. This problem relating to providing the state match could be mitigated if the medical schools received supplemental payments using the payment certification process which is based on prior expenditures. While the certification process does not require matching funds to be forwarded to AHCA, it sometimes results in the total supplemental payment being delayed. This is a concern because both schools have cash flow problems. Over the last year (2002), operating cash for the UF at Gainesville has been as low as 14 days of reserves and the Jacksonville campus has had as low as 1 day of operating cash. While the amount of cash reserves has recently increased at UF-Jacksonville due to a recent bond issue, UF-Gainesville may experience cash flow difficulties under the proposed plan."

Because the Medicaid fee schedule reimbursements are comparatively low, Medicaid patients throughout Florida typically have a difficult time securing subspecialty care. The Physician UPL/Enhanced Medicaid Payment Program was created to supplement

[9] Uncertainty Exists Regarding Florida's Proposed Physician Upper Payment Limit, OPPAGA, Report #03-15, February 2003.

Medicaid payments for services provided to Medicaid recipients treated at Florida's medical schools.

**Intergovernmental Transfers (IGT)**

IGT are fund exchanges between government and the state's Medicaid program. A common feature in state financing of the Medicaid program, IGT leverages the state's ability to draw down additional federal funds. IGT are a way for the state to fund the non-federal share of Medicaid expenditure, i.e., the state match requirement for the DSH and UPL program. The federal Medicaid statute explicitly recognizes the legitimacy of IGT involving tax revenues. Section 1903(w)(6)(A) of the Social Security Act specifies that "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider."

Historically, IGT have been used for several reasons including[10]:

- Traditional role of local governments in indigent care.
- Because of tight state budgets, local funding is needed.
- To enhance access to safety-net providers.
- To leverage local health care dollars as match for federal funds

Under the DSH and UPL program, for example, a county may transfer funds to the state Medicaid agency to support the state share of the DSH and UPL payment for a safety-net hospital.

Not all counties donate IGT to fund the match of the DSH and UPL program. In fact, the majority of IGT are generated by a few large urban counties (Dade, Broward, Duval, Orange and Hillsborough) that accounted for most of the state's share of the DSH funding. However, the IGT funds donated are used on a statewide basis. To place incentives for donor counties to continue to support a statewide DSH and UPL effort through IGT, incentives are provided to these counties in the form of premium returned to the qualifying hospitals within their counties. This premium currently is a 17% return to UPL paid to county designated hospitals for every dollar contributed in an IGT. This premium is reinvested by the county to support its charity care infrastructure. What remains is then distributed to hospitals using the UPL methodology established by the DSH Council (see Funding and Appropriations).

**Certified Public Expenditure (CPE)**

Although not a primary focus of this report, CPE are another method to claim for certain Medicaid expenditure. CPE are similar to IGT except that no money is transferred to the

[10] National Association of Public Hospitals, IGT – CPE Update, Goldstein and Associates, March 10, 2005

state Medicaid program. Instead, with CPE the county provider makes expenditures and certifies the expenditures to the state Medicaid program as being eligible for Medicaid under the state plan. The state then bills the Federal Government for the federal share of Medicaid expenditures. CPE are certified by the contributing public agency as representing expenditures that they have incurred in rendering care to either Medicaid or uninsured patients, and are eligible for federal matching dollars through the DSH program. Thus, while CPEs are expenditures providers incur, they are also a revenue source for the state's shares of DSH spending.

**Section 7 - Federal and State Law**

**Indigent and Charity Care**

Florida Health Care Responsibility Act

Part IV of Chapter 154, F.S., "Florida Health Care Responsibility Act" or HCRA was created in 1977 and was designed to ensure that the county of residence of an indigent person, who receives inpatient hospital services in a county other than the county of residence, will reimburse the hospital for those services.

The intent language that is part of HCRA, as delineated in s. 154.302, F.S., places the ultimate financial obligation for hospital treatment for qualified out-of-county indigent patients on the county in which the indigent patient resides. Under s. 154.309, F.S., the county known or thought to be the county of residence is given first opportunity to certify that a treated indigent is a resident of the county. If that county fails to make such a determination within 60 days of written notification by the hospital, the agency is to determine the indigent's county of residence. This determination is then binding on the county of residence.

Under s. 154.304, F.S., a hospital qualifies as "participating" in HCRA if it meets two criteria. First, the hospital has to have reported to the Agency for Health Care Administration (Agency) that it provided charity care, based on the hospital's most recent audited actual experience, in an amount where the ratio of uncompensated charity care days compared to total acute care inpatient days equals or exceeds 2 percent. Second, the hospital is required to either sign a formal agreement with a county to treat the county's indigent patients, or demonstrate to the agency that at least 2.5 percent of its uncompensated charity care, as reported to the agency, is generated by out-of-county residents. Under this section of statute, "regional referral hospitals" are hospitals which have met the 2 percent charity care obligation and which meet the definition of a teaching hospital as defined in s. 408.07, F.S.

The act defines "qualified indigent person" to mean a person who has been determined pursuant to s. 154.308, F.S., to have an average family income, for the 12 months preceding the determination, which is below 100 percent of the federal nonfarm poverty level; who is not eligible to participate in any other government program which provides

hospital care; who has no private insurance or has inadequate private insurance; and who does not reside in a public institution.

Section 154.316, F.S., requires any hospital admitting or treating any out-of-county patient who may qualify as indigent under HCRA to notify the county known or thought to be the county of residence within 30 days of the treatment or admission, or the county forfeits its right to reimbursement.

Under s. 154.306, F.S., a county's financial obligation for qualified applicants does not exceed 45 days per county fiscal year. The rate of payment set by this act is 100 percent of the per diem reimbursement rate currently in effect for the out-of-county hospital under Medicaid, except that those counties that were at their 10-mill cap on October 1, 1991, reimburse hospitals for such services at not less than 80 percent of the hospital Medicaid per diem. If a county has negotiated a formal agreement with a hospital, the payment rate set by the agreement is substituted for the payment rate set by the statute. The maximum a county is required to pay is equivalent to $4 multiplied by the most recent official state population estimate for the county.

Emergency Services

Section 395.1041, F.S., requires every general hospital that has an emergency department to provide emergency services and care for any emergency medical condition regardless of the ability to pay. This includes when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
    a. An emergency medical services provider who is rendering care to or transporting the person; or
    b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

Charity Care

For the purpose of the Medicaid program, "charity care" or "uncompensated charity care" is defined in Florida law[11] "as that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity."

[11] Section 409.911(1)(c),F.S.

Surtax

Section 212.055, F.S., authorizes counties to impose seven local discretionary sales surtaxes (taxes) on all transactions occurring in the county subject to the state tax imposed on sales, use, services, rental, and admissions. The tax rates, duration levied, method of imposition, and proceed uses are individually specified in s. 212.055, F.S. Several counties are using this authority to fund indigent care. These funds can be used as match through IGT.

| **Local Discretionary Sales Tax[12]** | | | |
|---|---|---|---|
| Tax | Authorized to levy (%) | Number counties authorized to levy tax | Number of counties levying tax |
| Indigent Care & Trauma Center Surtax | up to 0.5% | 5 | 1 |
| County Public Hospital Surtax | 0.5% (Miami-Dade County) | 1 | 1 |
| Voter-Approved Indigent Care Surtax | 0.5% or 1% | 60 | 2 |
| Voter-Approved Indigent Care Surtax. Counties with a population of fewer than 50,000 | Up to 1% | 26 | See below |

In the 2005 Session[13] s. 212.055, F.S., was amended to allow small counties to levy the Voter-Approved Indigent Care Surtax. Counties with a population of fewer than 50,000 residents are now authorized to levy the Voter-Approved Indigent Care Surtax of up to 1 percent rather than the 0.5 percent surtax authorized in existing law. In effect, the bill allows twenty-six counties to exercise this authority.

**DSH**

Federal law accords states broad flexibility to design their DSH programs as they like; consequently, there is much variation in how each state operates its program. Key areas in which state operations vary are found in:

- How much the state can spend on their DSH program.
- How the state determines which hospitals will receive DSH payments.
- How the state divides payments among eligible hospitals.
- How the state determines the size of DSH payments.

[12] Legislative Committee on Intergovernmental Relations, Local Discretionary Sales Surtax Rates in Florida's Counties for 2005
[13] SB 470 (Ch. 2005-242, LOF)

The upper payment limit (UPL) does not apply to disproportionate hospital payment adjustments made to hospitals as DSH payments have separate federal limitations. Furthermore, the methodology used in estimating the UPL must rely on data collected for services rendered on a fee-for-service basis. Rates such as those used for health maintenance organizations cannot be included in the calculation.

Sections 409.911- 409.9119, F.S., delineate the framework for the Disproportionate Share Hospital (DSH) programs. There are eight variations of the DSH program. These programs are designed to compensate certain facilities that provide a disproportionate share of Medicaid and/or charity care services by making quarterly payments as required by statute. The DSH program began in 1988. The eight programs include the:

- DSH program for hospitals.
  This program is authorized by section 409.911, F.S. and was implemented on July 1, 1988. The purpose of this program is to compensate hospitals that provide a disproportionate share of Medicaid and/or charity care services by making quarterly payments as required in the statute.
- DSH program for Regional Perinatal Intensive Care Centers.
  This program is authorized by section 409.9112, F. S., and was implemented on July 1, 1989. The Children's Medical Services Office of the Department of Health administers this program. To qualify for this DSH program, a hospital must first satisfy the Regular DSH criteria and then meet several programmatic requirements pertaining to neonatal intensive care and high-risk maternity care.
- DSH program for Teaching Hospitals.
  This program is authorized by section 409.9113, F.S., and was implemented on July 1, 1991. The program provides supplemental payments to statutorily defined teaching hospitals for increased costs associated with medical education programs and for tertiary health care services provided to indigent persons. Statutory Teaching hospitals are defined as those that are formally affiliated with an accredited medical school and have demonstrated activity in the area of medical education as reflected by a minimum of seven different accredited resident programs and the presence of 100 or more Full Time Equivalent (FTE) residents.
- DSH program for Mental Health Hospitals.
  This program is authorized by section 409.9115, F.S., and was implemented on October 1, 1992. The Department of Children and Families (DCF) administers the program and receives the state's General Revenue funds to operate the four qualifying state mental hospitals.
- DSH program for Rural Hospitals.
  This program is authorized by section 409.9116, F.S., and was implemented on May 1, 1994. A hospital must meet the statutory definition in s. 395.602, F.S., be certified as an obstetrical facility to receive federal funds and meet other programmatic requirements.
- DSH program for Primary Care Hospitals.

This program is authorized by section 409.9117, F.S., and was implemented on July 1, 1997. The purpose of this program is to provide supplemental payments to hospitals that have established a network for providing health care to uninsured individuals within a geographic boundary. The annual distribution is based on the percentage of Adjusted Hospital Uninsured Lives in the county relative to the total for all participating hospitals. There are several programmatic requirements as well. The allocation methodology must be approved by the Governor's Office, and each Primary Care hospital must submit an agreement between the county and the Agency before payments can be made.

- DSH program for Specialty Hospitals.
  This program is authorized by section 409.9118, F.S., and was implemented on July 1, 1997. The program provides supplemental payments to hospitals that treat communicable diseases for all admissions and receive all inpatient clients through referrals from county health departments. Currently, one hospital, A.G. Holley, meets the criteria.
- DSH program for Specialty Hospitals for Children
  This program is authorized by section 409.9119, F.S., and was implemented on July 1, 2000. To participate, a hospital must also meet the Regular DSH criteria and be licensed by the state as a specialty hospital for children as of January 1, 2000.

The DSH program for hospitals, teaching hospitals and rural hospitals are the only DSH programs currently active in the budget. The fundamental characteristic of these sections of statute is the delineation of an elaborate formula to calculate disproportionate share payments within each grouping of hospitals.

**Hospital UPL**

Federal regulations (42 CFR §447.272 and 42 CFR §447.332) provide that in the aggregate, payments to a group of health care facilities (for example hospitals) by a Medicaid agency may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.
For certain institutional providers, including hospitals, these upper payment limits apply in the aggregate to all payments to a particular class of providers, and are based on the estimated payment under Medicare payment principles.

Florida's UPL program relies on the use of IGT (dedicated local taxes) to provide the match for federal funds. This category of Special Medicaid Payments provide funds to hospitals serving low income individuals in an amount equal to 117% of the local tax contribution provided to the Medicaid program.

Section 409.908, F.S., delineates the authority for the Agency to reimburse certain hospital providers. Medicaid reimbursement for hospital services are based on cost reported, per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals are exempted from the caps contingent upon counties

contributing to the state's share of the cost. The agency is authorized to receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions. The agency has the authority to certify all local governmental funds used as state match for the Medicaid program.

Fifty five (55) hospitals in FY 2005-2006 are exempt from the Medicaid fee schedule limitations and received enhanced Medicaid rates or additional funding under the Upper Payment Limit program that was matched by IGT.

Medicaid reimburses hospitals for inpatient and outpatient services based on an approved Medicaid Reimbursement Plan. There are separate plans for inpatient services and outpatient services. The plans guide the Agency for Health Care Administration in the setting of facility specific per diem rates based on each facility's cost report. Hospitals are required to submit annual financial cost reports to the agency. The reports are prepared in accordance with the cost finding of Title XVIII (Medicare) principles of reimbursement except as modified by the hospital reimbursement plans. Per diem rates are prospective or interim, and are based on historical cost adjusted for inflation. Interim rates are based on budgeted costs and subject to an annual cost settlement.

The outpatient cost-based county reimbursement ceiling for variable costs per occasion of service is established for each county. The cost-based county ceilings apply to all hospitals as a limitation on the variable costs per occasion of service that a hospital will be paid. Hospitals will receive the lower of the hospital's occasion of service rate or the cost-based county ceiling. Rural and specialty psychiatric hospitals are exempt from this ceiling.

A target rate system for hospital outpatient rates is used to limit the growth in the cost-based county ceiling and facility specific rates between rate semesters. The target ceilings are adjusted each July by the Agency based on the prior January rate semester's ceilings and facility specific per diem multiplied times the allowable rate of increase. The target ceilings are adjusted each January and July based on the prior rate semester's county ceilings and facility specific rates times the allowable rate of increase.

**IGT**

Section 409.908, F.S., allows the Agency to receive funds from state entities, including, but not limited to, the Department of Health, the Board of Education, local governments, and other local political subdivisions, for the purpose of making payments, including federal matching funds, through the Medicaid outpatient reimbursement methodologies. Under this section of law, hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, F.S., or that participate in the statutory teaching hospital disproportionate share program may receive additional reimbursement.

**CPE**

Section 409.9071, F.S., requires that, subject to limitations established in the General Appropriations Act, the Agency develop policies and procedures to allow school districts to certify, as state Medicaid matching funds for certain Medicaid eligible services provided to exceptional education students. These services may include, but not be limited to, physical, occupational, and speech therapy services, behavioral health services, mental health services, transportation services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) administrative outreach for the purpose of determining eligibility for exceptional student education, and any other such services, for the purpose of receiving federal Medicaid financial participation. Students served through the funds must be exceptional education students that are Medicaid eligible. The services provided must be included in the child's individualized education plan and must be medically necessary.

School districts that certify matching funds must: verify the Medicaid eligibility of the children served; develop and maintain the records needed to document appropriate use of the funds; comply with all federal and state Medicaid law and policy; and be responsible for reimbursing any federal or state disallowance of funds.

Certified school funding is not available for the following services:

- Family planning.
- Immunizations.
- Prenatal care.

**Summary Timeline for Federal Action on DSH, IGT, and UPL**

Although the principal characteristics of DSH, UPL and IGT have fundamentally remained unchanged, over the years Congress has tweaked various funding and operational features of the programs aimed at enhancing the integrity of the program, and reducing growth in the long run.

1981 Congress requires states to make additional payments to DSH hospitals for inpatient services (Omnibus Budget Reconciliation Act of 1981)

1987 Congress establishes a minimum federal standard for qualifying as a DSH hospital (Omnibus Budget Reconciliation Act of 1987). CMS (then HCFA) issues UPL regulation limiting aggregate payments to state operated hospitals and nursing facilities and all other hospitals and nursing facilities (52 Fed. Reg. 28141, July 28, 1987)

1991 Congress
(1) Prohibits CMS from restricting IGT of state or local tax revenues, and
(2) Limits DSH spending in each state to 12 percent of total Medicaid spending (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of

1991)

1993 Congress imposes facility-specific ceilings on the amount of DSH payment states may make to DSH hospitals (Omnibus Budget Reconciliation Act of 1993)

1997 Congress specifies and phases down over FY 1997 – FY 2002 allotments of federal DSH funds for each state (Balanced Budget Act of 1997)

2000 Congress
(1) Increases state-specific allotments of federal DSH funds for FY 2001 and FY 2002, and
(2) Requires CMS to issue final regulations applying UPL to providers owned or operated by local governments and allowing for a transition period of up to 8 years (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000)

2001 CMS issues final regulations establishing UPL for local public providers and transition periods (66 Fed. Reg. at 3154, 3173, January 12, 2001)

2003 Congress increases state-specific allotments of federal DSH funds for FY 2004 by 16 percent (Medicare Prescription Drug, Improvement, and Modernization Act of 2003)

**Section 8 - Funding and Appropriations**

The DSH and UPL process that culminates in funding allocations to qualified hospitals in Florida as provided in the annual General Appropriations Act centers around the work of the DSH Council. The Medicaid Disproportionate Share (DSH) Council was originally created by proviso in the 2000-01 General Appropriations Act. Now codified in subsection (9) of s. 409.911, F.S., the council is charged with studying and making recommendations regarding the formula for the Regular Disproportionate Share Hospital Program (DSH) and alternative Medicaid financing options. The council includes representatives of the Executive Office of the Governor and of the Agency; representatives from teaching, public, private non-profit, private for-profit, and family practice teaching hospitals and representatives from other groups as needed. The council is required to submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year. These recommendations are considered by the Legislature and included in the Appropriations Act.

HB 3B passed during the December, 2005 Special Session amended s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council as the Low-Income Pool Council effective July 1, 2006. The revised Council will make recommendations to the Legislature regarding the Low-Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver. Low-Income Pool Council will consist of 17 members, including three representatives of statutory teaching hospitals, three representatives of

public hospitals, three representatives of nonprofit hospitals, three representatives of for-profit hospitals, two representatives of rural hospitals, two representatives of units of local government which contribute funding, and one representative of family practice teaching hospitals. The Low-Income Pool Council duties include:

- Making recommendations on the financing of the Low-Income pool and the disproportionate share hospital program and the distribution of their funds.
- Advising the Agency for Health Care Administration on the development of the Low-Income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
- Advising the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submitting its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

2001 - 2006 DSH, UPL and IGT PAYMENTS

The table below delineates the amount and growth of the DSH program, UPL program and IGT since FY 2001/2002. DSH payments to safety-net hospitals have decreased over this time period.

**CHANGES IN DSH, UPL AND IGT ALLOCATIONS OVER TIME**

| Payments | 2001-02 | % Growth | 2002-03 | % Growth | 2003-04 | % Growth | 2004-05 | % Growth | 2005-06 (Projected) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| Total DSH Hospital Payments | 373,970,094 | -27.000 | 272,998,406 | 16.781 | 318,809,612 | 0.647 | 320,873,253 | -13.71 | 276,852,938 |
| Grand Total UPL Payments[14] | 593,243,267 | -3.158 | 574,509,381 | 29.019 | 741,225,923 | 22.303 | 906,544,695 | 14.17 | 1,035,015,383 |
| Total IGT's* | 430,925,741 | -24.153 | 326,843,911 | 35.225 | 441,974,006 | 9.217 | 482,708,681 | 2.045 | 492,579,373 |
| | | | | | | | | | |
| Physician UPL Local Match (GR – IGT) | | | 15,116,532 | | 21,888,417 | 44.797 | 27,364,792 | 25.019 | |
| Federal Match | | | 24,538,589 | | 34,435,688 | 40.322 | 39,216,210 | 13.882 | |
| Total Funding | | | 39,655,121 | | $56,324,105 | 42.024 | $66,381,210 | 17.855 | |

According to the Agency, the annual variations in DSH and UPL payment are due to:

[14] The Hospital UPL allocation is made of two components, an enhanced Medicaid payment rate (rebasing) for services provided by hospitals and an allocation to address the uncompensated care provided to the uninsured.

- The DSH federal allotment is based upon a specific formula. As the state provides the match to draw down the federal dollars, the total each year changes based upon the change in the federal allotment. The total should be very consistent for the last several years, as the Medicare Modernization Act (MMA) froze the annual increase until the regular calculation created a higher allotment (estimated 2007 or later).

- The UPL payment based upon a formula tied to the amount of IGT received to fund the UPL program. As the total amount of the UPL program changes (including amount required to subsidize higher claims payments), this category changes based upon the amount of IGT required. The larger the other categories (combined), the greater this category.

- Exemptions to Ceilings/Rebasing (higher per diem rates paid to qualifying hospitals) can increase each year for several reasons: 1) as costs continue to increase, paying hospitals up to cost above their normal Medicaid limits costs more each year, 2) as caseloads grow, the volume of services increases, and 3) the policies regarding qualifications changes each year, therefore more hospitals typically qualify as the threshold becomes more lenient.

- Amounts may increase based upon recommendations of the DSH Council, or the size of the UPL balance. Should the UPL balance be able to accommodate more payments, the council may recommend changing the standards for the categories or increasing the amount available for distribution.

In summary, each year the GAA instructs the Agency regarding what policies is should implement for these payments. As these programs do not exist in statute, proviso substantiates what the Agency must do each fiscal year.

**HOSPITAL PARTICIPATING IN THE DSH – FY 2001/2002 to 2005/2006**

| Number of Hospitals who received payments | 2001-02 | % Growth | 2002-03 | % Growth | 2003-04 | % Growth | 2004-05 |
|---|---|---|---|---|---|---|---|
| DSH | 89 | -0.3146 | 61 | -0.0328 | 59 | -0.0169 | 58 |
| UPL | 83 | 0.0000 | 83 | 0.0361 | 86 | 0.0349 | 89 |

A spread sheet that delineates how UPL and DSH allocations are distributed among certain hospitals is provide in the Appendix of this report

**IGT**

For FY 2005-06, counties will provide approximately $493 million local government transfers through IGT. These funds were utilized to pay for the disproportionate share hospital program, as well as to provide special Medicaid payments to safety-net hospitals.

DSH payments to 58 qualifying hospitals will total approximately $277 million and UPL payments to 89 hospitals will total $1 billion.

**Section 9 - Federal approval of the Medicaid Reform Waiver - Special Terms and Conditions for the Low-Income Pool**

On October 19, 2005 the Agency received approval from the federal Centers for Medicare and Medicaid Services on the Medicaid Reform Section 1115 Demonstration waiver. Accompanying the approval were "Special Terms and Conditions" (STC) for the Florida Medicaid Reform section 1115 demonstration. The STC set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the demonstration for a 5-year period, from July 1, 2006, through June 30, 2011.

In the STC the Low-Income Pool replace the current UPL program. Low Income Pool can be used for health care expenditures (medical care costs or premiums) that are within the definition of medical assistance in Section 1905(a) of the Social Security Act. Under the federal terms and conditions, the Low-Income Pool can be used for health care expenditures incurred by the state, or by hospitals, clinics or by other provider types. LIP may be used for:

- Uncompensated medical costs of medical services for the uninsured;
- Medicaid shortfall (after all other Title XIX payments are made);
- Premium payments;
- Payments for provider access systems (PAS); and
- Insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS

The Low-Income Pool is a capped annual allotment of $1 billion total federal funding for each year of the 5-year demonstration period. Up to 10 percent of the capped annual allotment of the Low-Income Pool funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. Low-Income Pool funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

A critical provision of the STC will be the review by CMS of the validity of the source of IGT to fund the state match for the Low-Income Pool. Any disallowance of current IGT used to fund the UPL program could limit the state's ability to draw down Low-Income Pool funds.

The Specific terms and conditions regarding the implementation of the Low-Income Pool are as follows:

91. Low-Income Pool Definition. A Low-Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

92. Availability of Low-Income Pool Funds. Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low-Income Pool Milestones."

93. Reimbursement and Funding Methodology Document. In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low-Income Pool Milestones." Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

94. Low-Income Pool Permissible Expenditures. Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS

95. Low-Income Pool Expenditures - Non-Qualified Aliens. LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

96. Low-Income Pool Permissible Expenditures 10 percent Sub Cap. Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in item 91 of this section and Section XVI, "Low Income Pool Milestones."

97. Low-Income Pool Permissible Hospital Expenditures. Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost and this requirement is further clarified with the submission of a corresponding State Plan Amendment, as outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones."

98. Low-Income Pool Permissible Non-Hospital Based Expenditures. To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.

99. Permissible Sources of Funding Criteria. At least, 120 days prior to the demonstration implementation the State must submit for CMS approval the source of non-Federal share used to access the LIP, as outlined in the pre-implementation milestones. The State shall not have access to these funds until the source of non-Federal share has been approved by CMS. CMS assures the State that it will review the sources of non-Federal share in a timely manner. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

In addition the Agency must meet certain milestones regarding the Low-Income Pool including:

100. Pre-Implementation Milestones. The availability of funds for the LIP in the amount of $1 billion is contingent upon the following items prior to implementation:

a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement.
b. Florida's submission and CMS approval of a State Plan Amendment (SPA) that will terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Nothing herein precludes the State from submitting a State Plan Amendment reinstituting inpatient hospital supplemental payments upon termination of this demonstration. The State agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.
c. The State shall submit a State Plan Amendment for CMS approval limiting the inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96.
d. The State shall submit for CMS approval of all sources of non-Federal share funding to be used to access the LIP. The sources of the non-Federal share must be compliant with all Federal statutes and regulations.

e. The State's ability to access the restricted portion of funds at the time of implementation and for the duration of the demonstration shall be contingent upon the State's capacity to meet the following milestones outlined in this Section.

101. Demonstration Year 1 Milestones. The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91). The final document shall detail the payment mechanism for expenditures made from the LIP to pay for medical expenditures for the uninsured and qualified aliens including expenditures for 10 percent of the LIP used for other purposes as defined in paragraph 94. This document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include a projection of these amounts for each current year of operation, and final reporting of historical demonstration periods. Providers with access to the LIP and services funded from the LIP shall be known as the provider access system. Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

102. Demonstration Year 2 Milestones. At the beginning of demonstration year 2, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year one for a total of $1 billion.

The State will conduct a study to evaluate the cost-effectiveness of various provider access systems. The results of this study shall be disseminated to the provider access systems for the continuous improvement in the structure, scope and access to such systems.

During demonstration year 2, using the results of the study as a guideline, the State and CMS will define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the Low-Income pool for demonstration years 3 through 5.

By the end of demonstration year 2, the State will develop a plan for the continuous improvement of provider access systems and evaluation of the impact of these systems on the uninsured to be implemented in demonstration year 3.

By the end of demonstration year 2, the State will develop a plan for the statewide implementation of the demonstration by the end of waiver year 5.

103. Demonstration Year 3 Funding. At the beginning of demonstration year 3, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 2 for a total of $1 billion

Demonstration Year 3 Milestone. The State shall implement the indicators established under the plan for continuous improvement of provider access systems for the uninsured as indicated in demonstration year 2.

104. Demonstration Year 4. At the beginning of demonstration year four $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 3 for a total of $1 billion.

Demonstration Year 4 Milestone. The State shall identify the qualitative impact on the implemented indicators in demonstration year 3 on uninsured individuals. This analysis may require the State to adjust the indicators as necessary.

105. Demonstration Year 5. At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

**Section 10 - Issues**

Concerns and criticism of supplemental funding mechanism

There have been numerous concerns and criticism directed at the way some states operate the Disproportionate Share Hospital (DSH), the Upper Payment Limit (UPL) and Intergovernmental Transfer (IGT) payments to maximize the federal matching funds. These criticisms come from the Federal Administration, certain members of congress, CMS, and other Federal Government agencies.

In general, critics view the supplemental financing mechanism as designed solely to maximize Federal reimbursements to States, in contradiction to the federal and state cost-sharing principles as embodied in the FMAP and serve to disguise the source and final use of both Federal and State funds. One study estimated that the effective Medicaid federal match rate rises three percent as a result of states use of IGT to leverage UPL. Applying this assumption to the Florida UPL program, the true Federal match is closer to 63% rather than the actual 58.90 % in FFY 2005[15]. Another point of contention is that even with the infusion of federal Medicaid dollars, some states are not using the new funds to improve or expand allowable health care services for Medicaid beneficiaries or low-income and uninsured people. Like other Medicaid matching funds, federal funds generated through these mechanisms become unaccountable once they reach the states and can be used for a range of purposes, including non-health related budget items.[16] In the past, some states have been identified for "recycling" Federal dollars back to state general revenue. Florida was not identified as one of the state that "recycles".

In addition, the explosive growth in the supplemental payment mechanism has also generated related concerns. Federal and state UPL expenditures through all UPL arrangements grew from an estimated $10.3 billion in 28 states in FY 2000 to $11.2

[15] States' use of Medicaid UPL and DSH financing mechanisms. by Coughlin Teresa A, Bruen Brian K, King Jennifer; Health Affairs, 03/01/2004, Vol 23 (2), p245
[16] Ibid.

billion in 43 states in FY 2004. This growth would have been higher, but it occurred during a period were Congress and CMS acted to limit excessive UPL arrangement and claims[17]. When a state uses IGT to match Federal dollars for DSH and the UPL program, the state's share of the cost (general revenue) declines but increases the Federal share of the cost. As a result, there are recommendations and proposals to limit, alter or dismantle the DSH, UPL, and IGT programs.

The continuing challenge to the integrity of DSH, UPL and IGT is finding the proper balance between a state's flexibility to administer its Medicaid program and the shared federal-state fiduciary responsibility to manage program finances efficiently in a way that ensures the program's fiscal integrity. Some of the proposals to change these funding mechanisms include:

- New regulation to lower or cap the Medicaid UPL for public hospitals. This regulation would limit how much states could reimburse such hospitals, which would have the effect of reducing federal Medicaid matching payments to a number of states.
- Limits on the use of IGT and better accountability measures to ensure that IGT are not used as a vehicle to support inappropriate Medicaid financing.
- Limits on federal matching payments to states for reimbursements to DSH hospitals.
- The use of other strategies to serve the uninsured such as a "Low-Income pool".

In the aftermath of Hurricanes Katrina and Rita there are discussions in Congress to postpone any major changes to Medicaid that might cause a disruption or affect access to current services. However, the establishment of a Low-Income pool is a condition of the approved Florida Medicaid reform waiver and likely to receive the most scrutiny from the Legislature and providers.

Low-Income pool

In the Medicaid Reform waiver application the Agency specifically requested waivers of federal statutory provisions under the Social Security Act to provide for the establishment of a Low-Income Pool, in lieu of the UPL. The Low-Income Pool will be maintained by the state to provide direct payment and distributions to safety-net providers in the state for the purpose of providing coverage to the uninsured. Funds from the Low-Income Pool will be distributed to safety-net providers that meet certain state and federal requirements regarding charity care or uncompensated care.

On October 19, 2005 the Agency received approval from the federal Centers for Medicare and Medicaid Services (CMS) on the Medicaid Reform Section 1115 Demonstration waiver. Accompanying the approval were "Special Terms and Conditions" (STC) for the Florida Medicaid Reform section 1115 demonstration. The

[17] "Medicaid – State Efforts to Maximize Federal Reimbursement Highlight Need for Increased Federal Oversight", GAO, Publication 05-836T, June, 2005.

STC set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the Demonstration for a 5-year period, from July 1, 2006, through June 30, 2011. The Agency will need to comply with these terms and conditions (see Section 9 of the report). Among the most critical terms and conditions is the development of a reimbursement and funding methodology for the Low-Income Pool and the CMS approval of the source of non-Federal share used to access the Low-Income Pool.

Like UPL, the Low-Income Pool would function to support health care safety-net providers by subsidizing uncompensated care and increase access to care. A system or a formula would need to be established to distribute funds in the Low-Income Pool that validly addresses the burden of uncompensated care and that reduces the incentives to under serve the uninsured because of lack of compensation. The responsibility for developing a methodology to distribute funds from the Low-Income Pool will likely fall on the DSH council. The Agency anticipates that the DSH Council will play the same role it now plays in the UPL program and submit its findings and recommendations to the Governor and the Legislature regarding the use of the Low-Income Pool. HB 3B passed during the December, 2005 Special Session amended s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council as the Low-Income Pool Council effective July 1, 2006. The revised Council will make recommendations to the Legislature regarding the Low-Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver.

Some issues could emerge in the implementation of a low income pool. Among these are:

- The development of a reimbursement and funding methodology for the Low-Income Pool
- The amount allocated to the Low-Income Pool in comparison to historical UPL balances and growth rate
- How IGT would be used to leverage the federal funds in the Low-Income Pool
- Would current IGT be approved by CMS as match?
- Would local government (counties), through IGT, participate in a Low-Income Pool at the historical level of UPL and what would be the incentives for this participation?
- The types of entities that qualify for the Low-Income Pool versus the types of entities that are allowed to participate in the Low-Income Pool
- Will the physician UPL program be part of the Low-Income Pool?
- What challenges will there be in the transition from UPL to Low-Income Pool?
- What will be the effect of the Low-Income Pool on access to care by the uninsured?

The issues surrounding the use of the Low-Income Pool will be examined in the evaluation of the waiver and, in fact, is one of the five evaluation objectives delineated in

the waiver. The evaluation will also focus on describing the characteristics of individuals who receive services through the Low-Income Pool. As stated in the waiver application, the Agency expects that the availability of funds through the Low-Income Pool will increase access for select services for the uninsured in the service areas of the participating facilities.

The approved waiver projects on a statewide basis spending $1 billion per year or approximately $5 billion over the waiver's 5 year period on the Low-Income Pool for the uninsured. The $1 billion of Low-Income Pool funds represents the federal share (approximately $600 million) and state match or IGT (approximately 400 million).

The current UPL appropriation for FY 05/06 is approximately $1 billion. The UPL allocation is comprised of two components: an enhanced Medicaid rate (also referred as "rebasing") for services to hospitals and an allocation to address the uncompensated care by the uninsured. Applying these two components to the total UPL allocations in FY 05/06 approximately $300 million was allocated to hospitals for Medicaid rate rebasing (enhanced Medicaid payment rate) and $668 million to distribution for uncompensated care of the uninsured. The amount allocated to the Medicaid rebasing (enhanced rate) will remain at $300 million. This amount will come from other parts of the Medicaid budget. Because of the removal of rebasing from the $1 billion Low-Income Pool allocation, the state has a cushion of approximately $300 million in the Low-Income Pool for growth to provide payments for uncompensated care in the future.

The Agency is confident the Low-Income Pool will function much like the UPL program. The traditional UPL program will not be operating in the state in FY 06/07 since the Legislature approved the implementation of the waiver.

Managed care and supplemental funding mechanism

Another concern regarding the future of UPL or its replacement, the Low-Income Pool, and IGT is how they will be affected by an increasingly larger managed care environment. The UPL is based on calculations using fee-for-service (FFS) days paid directly by the Medicaid program to a hospital. Managed care funding is based on a capitation rate per recipient paid to the managed care entity. The managed care entity pays the hospital directly for services used by the plan's enrollee. Therefore, as managed care increases there are fewer FFS days billed by hospitals and, consequently, the lower the UPL aggregate amount available in the calculation. If all hospital care was provided through managed care, theoretically, there would be no UPL calculation because there would be no FFS days.

The IGT issue in a managed care environment centers on how specific hospitals would benefit from an IGT. If there are no FFS days billed by a hospital, the enhanced Medicaid rates could be paid to the managed care plans (e.g. unrelated entities to the funding governments). Under the current UPL program, supported by IGT, local governments can influence or direct that a portion of the funds benefit a specific hospital that participates in the UPL program. If the IGT under managed care funded only higher

capitation payments to managed care organizations, and the managed care organizations had no obligation to contract with specific hospitals or pay specific rates to a hospital, the counties would have no guarantees that their IGT would actually benefit their local providers. This could create a disincentive for counties to contribute or make IGT payments to the Medicaid program.

One possible strategy would be to count managed care hospital inpatient and outpatient days in the UPL or Low-Income Pool methodology. Another strategy would use Medicaid encounter data, required by supporting legislation and delineated in the Medicaid Reform waiver application, from the managed care organizations to determine the number of inpatient hospital days in a hospital and use this methodology in calculating hospital days. This would base utilization on a similar methodology used in calculating fee-for-service (FFS) days paid directly by the Medicaid program to a hospital. The viability of these methodologies will depend on the terms and conditions placed on the use of the Low-Income Pool by CMS

**Provisions to Protect Supplemental Funding Mechanisms**
The resolution of these issues is one of the keys to the viability of Medicaid reform and to legislative support for reform and is reflected in the legislative direction to the Agency in developing the Medicaid Reform waiver application. This legislative directive in the Medicaid Reform legislation requires that waiver authority to implement Medicaid reform be contingent upon:

- Federal approval to preserve the UPL for hospitals, including a guarantee of a reasonable growth factor.
- A methodology to allow the use of a portion of these funds to serve as a risk pool for demonstration sites
- Provisions to preserve the state's ability to use IGT.
- Provisions to protect the DSH program.

**How did the waiver approved by CMS impact these provisions?**

- UPL is gone and replaced by the Low-Income Pool. The Low-Income Pool should behave like UPL and that is the Agency's expectation. However, it will be contingent on the methodology for the distribution of the funds. Although it appears sufficient with a cushion of $300 million to fund based on historical UPL spending levels, capped at $1 billion a year for five years, there is no additional growth factor in the Low-Income Pool.
- In the terms and conditions of the approved waiver it appears that the Low-Income Pool can be used to provide supplemental payment for providers in addition to hospitals.

> "These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS."

However, the Agency plans to use the Low-Income Pool to supplement only certain hospitals. Thus, the physician UPL program and other providers are unlikely to receive any benefit from the Low-Income Pool.

- The Low-Income Pool could address the directive to preserve a portion of these funds to serve as a risk pool for demonstration sites. Again it is contingent on the methodology that is developed.
- The IGT program appears not to be affected by the terms and conditions of the approved waiver. However, CMS prior to the waiver implementation is requiring the Agency to submit for CMS approval the source of non-Federal share used or IGT to access the Low-Income Pool funds. The Agency will not have access to Low-Income Pool funds until the source of non-Federal share has been approved by CMS. There is a potential that CMS could disallow some of the IGT that would support the Low-Income Pool.
- The DSH program is not affected by the approve Medicaid Reform waiver and will remain the same. HB 3B passed during the December, 2005 Special Session amended s. 409.911(9), F.S., to modify the name, composition, and mission of the existing Medicaid Disproportionate Share Council as the Low-Income Pool Council effective July 1, 2006. The revised Council will make recommendations to the Legislature regarding the Low-Income Pool, which replaces the UPL funding program for safety-net hospitals under the terms and conditions of the federal waiver. Low-Income Pool Council will consist of 17 members, including three representatives of statutory teaching hospitals, three representatives of public hospitals, three representatives of nonprofit hospitals, three representatives of for-profit hospitals, two representatives of rural hospitals, two representatives of units of local government which contribute funding, and one representative of family practice teaching hospitals. The Low-Income Pool Council duties include:
- Making recommendations on the financing of the Low-Income pool and the disproportionate share hospital program and the distribution of their funds.
- Advising the Agency for Health Care Administration on the development of the Low-Income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
- Advising the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submitting its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

**Section 11 – Summary**

Safety-net hospitals that serve a large number of Medicaid and uninsured patients require a robust DSH and UPL program because Medicaid reimbursement rates are relatively low and because these hospitals typically receive little or no reimbursement for the costs that they incur on behalf of uninsured patients. The state has an interest in ensuring that these mechanisms are maintained or that as Medicaid evolves and other methods of ensuring

the financial viability of safety-net hospitals are in place that these financial mechanisms ensure the continuation of adequate support to safety-net hospitals in providing access to Medicaid recipients and to the uninsured.

The state also has an interest to ensure that current incentives are maintained so that counties continue to support the program with IGT. Without IGT to support the Low-Income Pool, the state would have to increase the general revenue appropriations to draw down the federal dollars. The Legislature can expect various provider types, e.g., physicians under the current physician UPL program, to make a valid case for their inclusion to receive a distribution from these funds. Support for the implementation of the waiver by these various provider types is likely to be contingent on whether they receive Low-Income Pool funds.

A critical task for the Legislature will be endorsing the methodology developed by the Agency and DSH Council for the distribution of funds in the Low-Income Pool that has the attributes and effects of the traditional UPL program and that provides incentives for counties to continue IGT contributions.

# APPENDIX I

**EFFECT OF RECOMMENDED PAYMENTS FOR REBASING, SPECIAL MEDICAID PAYMENTS**

**AND DSH PROGRAM FUNDING AT 17.5% COST OF FINANCING OPTION**

| | A | B | G | H | I | J | K | L | M | N | O | P | Q |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Provider | Provider | Total | Financing | 2005-06 Proposed DSH | | | Total | Provider Rebasing Costs | | |
| Medicaid | | | SMP | HH SMP | Provider | Fee | | Other | Total | Proposed | Using January 2005 Rates | | |
| Number | Provider Name | County | Total | Total | SMPs | Payments | Regular | DSH | DSH | by Provider | InPatient | Outpatient | Total |
| 100111 | Wuesthoff Hospital | Brevard | | | | | | | | | 544,178 | 342,615 | 886,793 |
| 100081 | Holmes Regional Medical Center | Brevard | 450,000 | | 450,000 | | | | | 450,000 | 0 | 0 | 0 |
| 100102 | Parrish Medical Center | Brevard | | | | | 1,270,222 | | 1,270,222 | 1,270,222 | 0 | 0 | 0 |
| 100099 | Cape Canaveral Hospital | Brevard | | | | | | | | | 0 | 0 | 0 |
| 120421 | Healthsouth Rehabilitation Hospital - Se | Brevard | | | | | | | | | 0 | 0 | 0 |
| 100285 | Saint Joseph Hospital Of Port Charlotte | Charlotte | | | | | | | | | 0 | 0 | 0 |
| 117463 | Columbia Fawcett Memorial Hospital | Charlotte | | | | | | | | | 0 | 0 | 0 |
| 100277 | Charlotte Regional Medical Center | Charlotte | | | | | | | | | 0 | 0 | 0 |
| 100315 | Naples Community Hospital | Collier | | 250,000 | 250,000 | 2,467,500 | | | | 2,717,500 | 1,119,555 | 59,492 | 1,179,047 |
| 260037 | G. Pierce Wood Hospital | Desoto | | | | | | | | | 0 | 0 | 0 |
| 101923 | Desoto Memorial Hospital | Desoto | 357,975 | | 357,975 | | | | | 357,975 | 0 | 0 | 0 |
| 100765 | Sacred Heart Hospital | Escambia | 630,000 | 466,977 | 1,096,977 | 220,313 | | | | 1,317,290 | 3,724,611 | 862,736 | 4,587,347 |
| 100749 | Baptist Hospital Of Pensacola | Escambia | 450,000 | 450,000 | 900,000 | 220,313 | | | | 1,120,313 | 4,505,312 | 715,349 | 5,220,661 |
| 113212 | West Florida Regional Medical Center | Escambia | 450,000 | | 450,000 | | | | | 450,000 | 0 | 0 | 0 |
| 260011 | Florida State Hospital | Gadsden | | | | | | | | | 0 | 0 | 0 |
| 100811 | Gadsden Community Hospital | Gadsden | 148,388 | | 148,388 | | | | | 148,388 | 0 | 0 | 0 |
| 119784 | Florida State Hospital - Med. Surg. | Gadsden | | | | | | | | | 0 | 0 | 0 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 100862 | Hendry Regional Medical Center | Hendry | 164,317 | | 164,317 | | 93,749 | | 93,749 | 258,066 | 0 | 0 | 0 |
| 100897 | Highlands Regional Medical Center | Highlands | | | | | | | | | 0 | 0 | 0 |
| 100901 | Florida Hospital - Walker | Highlands | | | | | | | | | 0 | 0 | 0 |
| 101044 | Indian River Memorial Hospital | Indian River | | | | 10,456,136 | | | | 10,456,136 | 0 | 0 | 0 |
| 120014 | Sebastian Hospital | Indian River | | | | | | | | | 0 | 0 | 0 |
| 120341 | Healthsouth Rehabilitation Hospital - Tr | Indian River | | | | | | | | | 0 | 0 | 0 |
| 101079 | Leesburg Regional Medical Center | Lake | | | | 3,759,576 | | | | 3,759,576 | 0 | 0 | 0 |
| 101087 | South Lake Memorial Hospital | Lake | 228,031 | | 228,031 | | | | | 228,031 | 0 | 0 | 0 |
| 101095 | Florida Hospital - Waterman | Lake | | | | 4,146,999 | | | | 4,146,999 | 0 | 0 | 0 |
| 101117 | Columbia East Pointe Hospital | Lee | | | | | | | | | 0 | 0 | 0 |
| 102253 | Columbia Gulf Coast Hospital - Ft. Myers | Lee | | | | | | | | | 786,399 | 235,087 | 1,021,486 |
| 101109 | Lee Memorial Hospital | Lee | 450,000 | 1,200,000 | 1,650,000 | 19,126,725 | 6,054,301 | | 6,054,301 | 26,831,026 | 5,354,316 | 680,331 | 6,034,647 |
| 111341 | Southwest Florida Regional Medical Cente | Lee | | | | | | | | | 0 | 0 | 0 |
| 119717 | Cape Coral Hospital | Lee | | | | | | | | | 0 | 0 | 0 |
| 101133 | Tallahassee Memorial Healthcare | Leon | 233,088 | 54,402 | 287,490 | 2,277,827 | | | | 2,565,317 | 6,897,379 | 914,721 | 7,812,100 |
| 119806 | Tallahassee Community Hospital | Leon | | | | | | | | | 0 | 0 | 0 |
| 120332 | Healthsouth Rehabilitation Hospital - Ta | Leon | | | | | | | | | 0 | 0 | 0 |
| 101184 | Martin Memorial Hospital | Martin | | | | | | | | | 0 | 0 | 0 |
| 111368 | Golden Glades Regional Med Center | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 100439 | Mercy Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 100536 | Palm Springs General Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 100544 | Pan American Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 104604 | Palmetto General Hospital | Miami-Dade | 233,088 | | 233,088 | | | | | 233,088 | 7,933,535 | 934,950 | 8,868,485 |
| 109606 | Coral Gables Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 100421 | Jackson Memorial Hospital | Miami-Dade | 6,710,750 | 3,322,365 | 10,033,115 | 156,843,321 | 104,699,871 | | 104,699,871 | 271,576,308 | 64,022,703 | 11,151,156 | 75,173,859 |
| 100358 | Baptist Hospital - Miami | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 120138 | Kendall Regional Medical Center | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 120057 | Healthsouth Larkin Hospital-Miami | Miami-Dade | | | | | | | | | 0 | 0 | 0 |
| 100625 | Westchester General Hospital | Miami-Dade | | | | | | | | | 2,306,019 | 38,299 | 2,344,318 |
| 100609 | Miami Childrens Hospital | Miami-Dade | 1,450,000 | 5,400,229 | 6,850,229 | | | | | 6,850,229 | 9,752,813 | 611,866 | 10,364,679 |
| 102261 | SMH Homestead Hospital | Miami-Dade | 420,852 | | 420,852 | | | | | 420,852 | 0 | 0 | 0 |
| 102385 | Parkway Regional Medical Center | Miami-Dade | | | | | | | | | 3,197,363 | 287,549 | 3,484,912 |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 100366 | Cedars Medical Center | Miami-Dade | | | | | | | | | 2,605,676 | 6,441 | 2,612,117 | |
| 100412 | Hialeah Hospital | Miami-Dade | | | | | | | | | 1,792,181 | 302,416 | 2,094,597 | |
| 100498 | North Shore Medical Center | Miami-Dade | | | | | | | | | 1,992,985 | 618,936 | 2,611,921 | |
| 120375 | Columbia Aventura Hospital & Medical Cen | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 120286 | Doctors' Hospital - Coral Gables | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 100447 | Miami Heart Institute | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 100471 | University Of Miami Hospital & Clinics | Miami-Dade | | | | | | | | | 314,094 | 998,852 | 1,312,946 | |
| 100587 | South Miami Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 100595 | South Shore Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 100463 | Mt. Sinai Medical Center | Miami-Dade | 1,048,317 | 9,072,075 | 10,120,392 | | | | | 10,120,392 | 5,027,921 | 156,087 | 5,184,008 | |
| 119938 | Vencor Hospital-Coral Gables | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 120022 | Bon Secours | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 101702 | West Gables Rehabilitation Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 102709 | Healthsouth Hospital - Miami | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 110060 | Deering Hospital | Miami-Dade | | | | | | | | | 0 | 0 | 0 | |
| 116483 | Ann Bates Leach Eye Hospital | Miami-Dade | | | | | | | | | 431,696 | 1,819,473 | 2,251,169 | |
| 120227 | St. Anthony'S Hospital | Pinellas | | | | 6,099,470 | | | | 6,099,470 | 0 | 0 | 0 | |
| 115193 | Columbia Northside Medical Center | Pinellas | | | | 114,430 | | | | 114,430 | 1,399,275 | 92,636 | 1,491,911 | |
| 101591 | Sun Coast Hospital | Pinellas | 233,088 | | 233,088 | 229,668 | | | | 462,756 | 396,873 | 86,948 | 483,821 | |
| 101583 | Morton F. Plant Hospital | Pinellas | 233,088 | | 233,088 | 6,373,187 | | | | 6,606,275 | 5,371,937 | 825,251 | 6,197,188 | |
| 101541 | Mease Hospital - Dunedin | Pinellas | | | | 674,110 | | | | 674,110 | 0 | 0 | 0 | |
| 101613 | Helen Ellis Memorial Hospital | Pinellas | | | | 233,950 | | | | 233,950 | 0 | 0 | 0 | |
| 120103 | St. Petersburg General Hospital | Pinellas | | | | 153,569 | | | | 153,569 | 0 | 0 | 0 | |
| 120111 | Palms Of Pasadena | Pinellas | | | | 7,305 | | | | 7,305 | 0 | 0 | 0 | |
| 101516 | All Children's Hospital | Pinellas | 1,450,000 | 6,637,413 | 8,087,413 | | | | | 8,087,413 | 9,411,740 | 588,887 | 10,000,627 | |
| 102768 | Vencor Hospital-St. Petersburg | Pinellas | | | | | | | | | 72,902 | 0 | 72,902 | |
| 101567 | Bayfront Medical Center | Pinellas | 683,088 | 215,975 | 899,063 | 11,251,187 | | | | 12,150,250 | 4,267,229 | 201,914 | 4,469,143 | |
| 120081 | Mease Hospital - Countryside | Pinellas | | | | | | | | | 0 | 0 | 0 | |
| 101753 | Healthsouth Rehabilitation Hospital - La | Pinellas | | | | | | | | | 0 | 0 | 0 | |
| 101966 | Clearwater Community Hospital | Pinellas | | | | | | | | | 0 | 0 | 0 | |
| 102598 | Columbia Edward White Hospital | Pinellas | | | | 38,741 | | | | 38,741 | 0 | 0 | 0 | |
| 119741 | Largo Medical Center | Pinellas | | | | 221,879 | | | | 221,879 | 0 | 0 | 0 | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 101788 | Central Florida Regional Hospital | Seminole | | | | | | | | | 0 | 0 | 0 |
| 119997 | South Seminole Community Hospital | Seminole | | | | | | | | | 0 | 0 | 0 |
| 119695 | Lawnwood Regional Medical Center | St Lucie | | | | | | | | | 3,106,006 | 296,266 | 3,402,272 |
| 119971 | Columbia Medical Center-Port St. Lucie | St Lucie | | | | | | | | | 0 | 0 | 0 |
| 101842 | Halifax Medical Center | Volusia | 683,088 | | 683,088 | 13,153,003 | 6,306,018 | | 6,306,018 | 20,142,109 | 6,335,394 | 1,569,570 | 7,904,964 |
| 101877 | Memorial Hospital - West Volusia | Volusia | | | | | | | | | 0 | 0 | 0 |
| 101834 | Bert Fish Memorial Hospital | Volusia | | | | 537,968 | | | | 537,968 | 0 | 0 | 0 |
| 101869 | Memorial Hospital - Ormond Beach | Volusia | | | | | | | | | 0 | 0 | 0 |
| 101826 | Volusia Medical Center | Volusia | | | | | | | | | 0 | 0 | 0 |
| 101851 | Columbia Medical Center-Peninsula | Volusia | | | | | | | | | 0 | 0 | 0 |
| 120049 | Columbia Daytona Medical Center | Volusia | | | | | | | | | 0 | 0 | 0 |
| | | | | | | | | | | | 0 | 0 | 0 |
| | | | | | | | | | | | 0 | 0 | 0 |
| | Totals | | 16,707,159 | 27,069,436 | 43,776,595 | 238,607,175 | 111,005,889 | 0 | 111,005,889 | 344,498,005 | 121,804,807 | 19,652,547 | 141,457,354 |